PRINTED: 08/24/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		157577	B. WIN	G_			⋜ 2/2012
	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 138 W CARMEL DR CARMEL, IN 46032	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS	,	{G 0	000]	}		
		an extended Federal Home survey conducted 5/15/12.					
	Survey date: 6/28/12	to 7/2/12					
	Facility #: 004804						
	Medicaid vendor #: 2	200828410					
	leader	cker, RN, PHNS Team					
	Bridget member	Boston, RN , PHNS Team					
	Census: 84						
	deficiencies were cor	een standard level of rected; two conditions and I deficiencies were recited.					
	own home health aid evaluation program for beginning 7/2/12 through out of compliance with Participation 42 CFR	484.16: Group of nel and 484.52: Evaluation of					
	Quality Review; Linda Dubak, R. July 6, 2012						
{G 133}	484.14(c) ADMINIST	RATOR	{G 1	33]	}		
		no may also be the n or registered nurse required of this section, organizes and					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SUF	ED
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	OVIDER OR SUPPLIER			138	ET ADDRESS, CITY, STATE, ZIP CODE B W CARMEL DR ARMEL, IN 46032		
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{G 133}	ongoing liaison amon	e 1 ongoing functions; maintains g the governing body, the personnel, and the staff.	{G 1	33}			
	Based on administra review, and interview ensure an ongoing ev was designed to obje monitor and evaluate appropriateness of pa identified problems, a and maintained liaiso professional personne	atient care, resolved nd improved patient care					
	administrator indicate evaluations are to be [professional advisory in July 2012 to start. 2. Review of an undadocument dated 5/15 Quality Assurance". assessment donee evidence an ongoing evaluation to identify patient care. 3. The undated police	done yearly by the "PAB" y group] and the proposal is ated administrative /12 titled "ABC Home Health The document stated "QA xit by state" failed to objective and systematic problems and improve					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157577	B. WIN				₹
NAME OF PR	OVIDER OR SUPPLIER	157577		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	07/02	2/2012
ABC HOM	ECARE LLC			13	8 W CARMEL DR ARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{G 133}	indicated the policy w "Membership will inclusione registered nurse, representation from or disciplines Functi establishment and an covering the scope of and discharge policie plans of care, emerge personnel qualification Assist in identification and supports the age the alleviation or resord Periodically reviews the recommends needed professional advisory sub - committees: A. B. Quality Assurance 4. The undated policie Evaluation" was proving administrator on June indicated the policy wand Procedure Review agency patient policies and procedure documented in the act Recommendations shapes presentation to the Botal St. On 6/29/12 at 250 indicated that she had returned back to work alternate administrator correction during that	e 28, 2012 at 317 PM, who as current and stated, ude at least one physician, and appropriate ther professional ions: Participates in the nual review of policies is services offered, admission is, medical supervision, ency care, clinical records, ins, and program evaluation. In of community health needs incy in assuming its role in lution of problems. The agency's programs and changes The board will function with two in Audit Review Committee. The administrator shall sional Advisory Board to it care and administrative in the summarized for its constant in the summarized for its constant in the plan of time.	{G 1				
{G 144}	484.14(g) COORDINA	ATION OF PATIENT	{G 1	44}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	20//IDED OD OUDDUED	157577				07/0	2/2012
	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE CARMEL DR		
ABC HOM	IECARE LLC			CARM	IEL, IN 46032		
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{G 144}			{G 1	44}			
	Based on clinical recvisit observation, and to ensure coordination with other entities that (# 11) of 1 clinical recidentified as received other entities and falls summaries included pwas sent to the physic where services were days, with the potentireceived home health Findings include: 1. Clinical record # 1 indicated the patient reclinical record evidence certification period 3/2 signed by the administ the certification period signed by the alternation for skilled nursing visi 6-8 hours, 8-10 hours hours,; 2-3 WK [week authorized through mailed to evidence coordination with the certification period signed by the alternation for skilled nursing visi 6-8 hours, 8-10 hours hours,; 2-3 WK [week authorized through mailed to evidence coordination with the certification period signed by the alternation for skilled nursing visi 6-8 hours, 8-10 hours hours, 2-3 WK [week authorized through mailed to evidence coordination with the certification period signed by the alternation for skilled nursing visi 6-8 hours, 8-10 hours hours, 2-3 WK [week authorized through mailed to evidence coordination with the properties of the coordination for skilled nursing visi 6-8 hours, 8-10 hours hours, 2-3 WK [week authorized through mailed to evidence coordination for skilled nursing visi 6-8 hours hours have been supplied to evidence coordination for skilled nursing visi 6-8 hours have been supplied to evidence coordination for skilled nursing visi 6-8 hours have been supplied to evidence coordination for skilled nursing visi 6-8 hours have been supplied to evidence coordination for skilled nursing visi 6-8 hours have been supplied to evidence coordination for skilled nursing visi 6-8 hours have been supplied to evidence coordination for skilled nursing visi 6-8 hours have been supplied to evidence coordination for skilled nursing visi 6-8 hours have been supplied to evidence coordination for skilled nursing visi 6-8 hours have been supplied to evidence coordination for skilled nursing visi 6-8 hours have been supplied to evidence coo	pertinent information and cian in 1 of 2 records (11) provided for more than 60 all to affect all patients that services from this agency. 1, start of care 12/26/06, equired 24 hour care. The ced a plan of care for the 29/12 through 5/27/12 strator and a plan of care for d 5/28/12 through 7/26/12 e administrator with orders ts "1 - 2 /d, for 2-4 hours,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF	ED
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	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 138 W CARMEL DR CARMEL, IN 46032	, , , , , ,	
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{G 144}	A. An undated to author and signature, patient's application and listed all of the patient of these hours through clinical record failed the care with the provided and stated, "Single of the clinical synopsis of the clinical synopsis of the clinical plan of care, report to the physician and stated, "Liver bid overnight, no new me changes. Has received nurse] service for AD care including bathing [incontinent] care, ski maintenance of specific feedings. Pleased with the plan of continent of	primation and was sent to the 2 certification periods. Apped document, void or was attached to this for medicaid PA services atients from the same receiving services from this patient the document over - 128 hours / month. The direct care staff for some h McSherr , Inc." The coinclude any coordination of ridentified as McSherr Inc. -28 defined a summary ummary Report means a see pertinent factors from the right a patient requiring a which is submitted as a n." are with beginning date area titled "60 day summary" psy 3/20/12, in hospital edications, or medication red ordered SN [skilled L [activities of daily living] g, dressing, incont in care, foot care, oral care, all equipment, respiratory TX on administration and the care provided."	{G ^	144)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
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{G 144}	service for ADL care i incont [incontinent] coral care, maintenance respiratory TX [treatmadministration and fee provided." E. The 60 day so a clinical synopsis of F. During a home the caregiver and emadditional care and so McSherr Inc. The careceived 181 hours of through McSherr Inc. home health agency. patient experienced dead to the continuous oxygen at and use of a VIA vest clear lungs, could not allergies, and was cheated and alternate administrator on 6/28 policy was a new / redate, titled "Identify P Coordination" stated, designate a common document other provi SN / RN doing the as care] and ROC [resur	are, skin care, foot care, are, skin care, foot care, are of special equipment, ment], medication addings. Pleased with care ummaries failed to evidence the patients care. e visit on 7/2/12 at 10 AM, ployee L confirmed ervices were provided by regiver indicated the patient of waiver hours a month and that this provider was a Employee L indicated the laily seizures, was monitored off or caregiver, was on 24 %, nebulizer treatments 4 times a day to maintain longer go outside due to	{G 1	144}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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{G 144} {G 151}	Continued From page be documented and u changes." 484.16 GROUP OF F PERSONNEL	updated as often as it	{G 14				
	Based on policy and review and interview, agency failed to ensure personnel was former representation of a pl disciplines that provid agency (See G 152); professional personnel and approved the agency and approved the agency for group of profecommitted to participate of the agency's progratiaison with other health community and in the information program and ensure the group of profecommitted to participate of the agency's progration with other health community and in the information program and the group of professions.	hysician and other de services on behalf of the failed to ensure a group of el was formed that reviewed ency's policies and for the annual program (3); failed to ensure there is a essional personnel ate in an ongoing evaluation am and assist in maintaining Ith care providers in the					
{G 152}	has resulted in the ag compliance with the 0 484.16: Group of Pro	Condition of Participation fessional Personnel tial to affect all the patients	{G 15	52}			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{G 152}		al personnel includes at nd one registered nurse ealth nurse), and ation from other	{G ·	152}			
	Based on administrar review and interview, a group of profession and included represer other disciplines that of the agency in 1 of to effect all patients of	not met as evidenced by: tive document and policy the agency failed to ensure al personnel was formed ntation of a physician and provide services on behalf I agency with the potential f this agency.					
	administrator / alternal indicated she wrote the that there was no door or preliminary work coreview, and that there professional advisory their plan of correction director was out of toor return until after Indep She indicated she had new policies and procesult of the recent surand that the agency of administrative docum and procedures, any assertion of the recent surand procedures.	ne plan of correction and umentation of any planning ompleted available for was not a meeting with the board as documented in a because the new medical wn and not expected to be pendence Day (7/4/12). It developed and wrote the redures implemented as a survey and plan of correction					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLETI	
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{G 152}	problems and how to resolution, and addre effectiveness of the p accomplished and do she does not have co professional advisory a member. 2. On June 29, 2012 administrator indicate was June 25, 2012 ar some of the plan of co and procedures and t documentation of the procedures, the impledate, she indicated the planning or preliminal agency's annual evaluation and that the new medical director position and th	g annual program and o prioritize any identified document the agency as how monitoring of the rogram would be cumented. She indicated immunication with the group and that she was not at 3:20 PM, the d her first day back to work and indicated she had read correction and new policies that there was no see new polices and ementation of and effective ere was not evidence of any ry work towards the uation. She indicated the ion of the PAG has changed lical director had not eetings yet nor was there is evidence that this physician sition and its responsibilities. The professional and registered nurse, and	{G ·	152}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		CONSTRUCTION	(X3) DATE SUI	ED
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{G 152}	and supports the age the alleviation or resord Periodically reviews to recommends needed professional advisory sub - committees: A. B. Quality Assurance 4. The undated police Evaluation" stated, "For Review: The administ Professional Advisory patient care and administrative mashall be summarized Board of Directors." 5. Administrative docevidence the agency evaluation of its progroupolicies and procedur review, including criteria of any identified problemonitoring of the effect would be accomplished. 6. On June 28, 2012 presented an agency and titled "Profession and reviewed. The dattendance at the medirector and the adminursing. The docume information notes as interested.	of community health needs need in assuming its role in solution of problems. The agency's programs and changes The board will function with two Audit Review Committee Committee." Ty titled "Annual Program Policy and Procedure Strator shall meet with the Policy Board to review agency inistrative policies and ew shall be documented in Innual. Recommendations for presentation to the suments review failed to planned an annual ram and included a review of the and an administrative ratio to prioritize the resolution dems, and address how citiveness of the program red and documented. The alternate administrator document dated 11/9/11 al Advisory Board Meeting occument evidenced the eting was only the medical inistrator / director of rent contained the same presented during the first uned by administrator and	{G ^	52}			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF	
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{G 153}	and annually reviews governing scope of seand discharge policies plans of care, emerge personnel qualification At least one member owner nor an employed. This STANDARD is run Based on administrative review, and interview, a group of professional that reviewed and appropersonnel qualification for the agency annual 1 with the potential to agency. Findings include: 1. On June 29, 2012 administrator / alternatindicated she wrote that there was not door preliminary work correview, and that there professional advisory their plan of correction director was out of tour return until after Indeptions.	onal personnel establishes the agency's policies ervices offered, admission is, medical supervision and ency care, clinical records, ins, and program evaluation. of the group is neither an ee of the agency. Into the agency is neither an ee of the agency failed to ensure all personnel was formed proved the agency's policies ervices, admission and edical supervision and plans are, clinical records, ins and participated in a plan all program evaluation in 1 of effect all patients of this at 3:10 PM, the alternate at director of nursing in plan of correction and cumentation of any planning	{G ·	153}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETI	
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{G 153}	new policies and procresult of the recent surand that the agency dadministrative docum and procedures, any agency planning toward document an ongoing including the criteria troblems and how to resolution, and addresseffectiveness of the procedures and do she does not have corposessional advisory a member. 2. On June 29, 2012 administrator indicate was June 25, 2012 ar some of the plan of corposessional advisory and procedures and trocumentation of the procedures, the impledate, she indicated the planning or preliminar agency's annual evaluation of advisory group] has corposedured director had meetings yet nor was evidence that this phy position and its responsal. 3. On July 2, 2012 at indicated the agency documentation of whe	redures implemented as a survey and plan of correction id not maintain entation of the new polices agency development and ards how the agency was to annual program and or prioritize any identified document the agency as how monitoring of the rogram would be cumented. She indicated mmunication with the group and that she was not at 3:20 PM, the d her first day back to work and indicated she had read prection and new policies that there was no see new polices and ementation of and effective ere was not evidence of any ry work towards the uation. She indicated the the PAG [professional hanged and that the new not participated in any there any documentation to resician has agreed to the insibilities. 1:25 PM, the administrator did not maintain en polices were developed, revised, and implemented	{G ·	153}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PE			1:	REET ADDRESS, CITY, STATE, ZIP CODE 38 W CARMEL DR CARMEL, IN 46032	0770.	2/2012	
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{G 153}	at least one physician appropriate represent professional discipline each meeting and material agency records. Fund the establishment and covering the scope of and discharge policie plans of care, emerge personnel qualification Assist in identification and supports the age the alleviation or resource periodically reviews the recommends needed professional advisory sub - committees: A. B. Quality Assurance 5. The undated policies Evaluation stated, "Freview: The administrative materials and procedures. The review administrative materials be summarized Board of Directors." 6. On June 28, 2012 presented an agency and titled "Profession and reviewed. The discourse of the discours	y titled "Professional d, "Membership will include d, one registered nurse, and ation from other es Minutes are kept of dintained in permanent ctions: Participates in d annual review of policies es services offered, admission es, medical supervision, ency care, clinical records, ns, and program evaluation. of community health needs ncy in assuming its role in lution of problems. The agency's programs and changes The board will function with two Audit Review Committee Committee."	{G ^	53}			

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	OVIDER OR SUPPLIER		1	138	T ADDRESS, CITY, STATE, ZIP CODE W CARMEL DR RMEL, IN 46032		
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{G 153}	information notes as p	nistrator / director of ent contained the same oresented during the first ned by administrator and tle head.	{G ^				
	frequently to advise the issues, to participate agency's program, and maintaining liaison wi	nunity and in the agency's					
	Based on agency ad policy review, and into ensure there was a spersonnel committed evaluation of the agermaintaining liaison wi providers in the commonmunity informatio	not met as evidenced by: ministrative document and erview, the agency failed to becific group of professional to participate in an ongoing ncy's program and assist in th other health care nunity and in the agency's n program in 1 of 1 agency ffect all patients of the					
	administrator / alterna indicated she wrote th that there was no doo or preliminary work co	ne plan of correction and sumentation of any planning					

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{G 154}	their plan of correction director was out of tour return until after Indep She indicated she had new policies and proof result of the recent surand that the agency of administrative document and procedures, any agency planning toward document an ongoing including the criterial to problems and how to resolution, and addrest effectiveness of the placomplished and do she does not have comprofessional advisory a member. 2. On June 29, 2012 administrator indicated was June 25, 2012 at some of the plan of company and procedures and the documentation of the procedures, the impledate, she indicated the planning or preliminating agency's annual evaluation of advisory group] has comedical director had meetings yet nor was	board as documented in n because the new medical wn and not expected to be be bed and wrote the bedures implemented as a survey and plan of correction did not maintain entation of the new polices agency development and ards how the agency was to gannual program and to prioritize any identified document the agency so show monitoring of the rogram would be cumented. She indicated emmunication with the group and that she was not at 3:20 PM, the did her first day back to work and indicated she had read correction and new policies that there was no see new polices and ementation of and effective the page of the page	{G ·	154}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	15/5//		138	ET ADDRESS, CITY, STATE, ZIP CODE B W CARMEL DR IRMEL, IN 46032	07/02	2/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO T		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{G 154}	3. On July 2, 2012 at indicated the agency documentation of who approved, reviewed, and offered the agency process of being rety. 4. The undated polic Advisory Board" state at least one physician appropriate represent professional discipline each meeting and ma Participates in the estreview of policies covoffered, admission and medical supervision, care, clinical records, and program evaluati in assuming its role in of problems. Periodic programs and recommendation and recommendation of problems. Periodic programs and recommendation of professional advisory patient care and administrative mashall be summarized Board of Directors."	at:25 PM, the administrator did not maintain en polices were developed, revised, and implemented by polices were in the ped. y titled "Professional ed, "Membership will include an one registered nurse, and tation from other es Minutes are kept of an intained Functions: tablishment and annual ering the scope of services and discharge policies, plans of care, emergency personnel qualifications, on supports the agency and the alleviation or resolution cally reviews the agency's mends needed changes sory board will function with: A. Audit Review Assurance Committee."	{G ·	154}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			1:	REET ADDRESS, CITY, STATE, ZIP CODE 38 W CARMEL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
{G 154}	and reviewed. The deattendance at the medirector and the adminursing. The docume information notes as parvey and is now signontains an agency to 484.16(a) ADVISORY FUNCTION	al Advisory Board Meeting" ocument evidenced the eeting was only the medical inistrator / director of ent contained the same presented during the first gned by administrator and ttle head. Y AND EVALUATION	{G 1				
	Based on agency ad policy review and interensure the group of preetings were documed 1 agency. Findings include: 1. On June 29, 2012 administrator / alternatindicated she wrote that there was no docor preliminary work coreview, and that there professional advisory their plan of correction director was out of to return until after Indep She indicated she documents.	at 3:10 PM, the alternate at director of nursing he plan of correction and cumentation of any planning ompleted available for e was not a meeting with the board as documented in he because the new medical win and not expected to pendence Day (7/4/12). The plan of communication advisory group and that she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	10.011	l	13	EET ADDRESS, CITY, STATE, ZIP CODE 8 W CARMEL DR ARMEL, IN 46032	07/0.	2/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{G 155}	was June 25, 2012 ar some of the plan of common and procedures and the documentation of the procedures, the imple date, she indicated the planning or preliminal agency's annual evaluation physician position of advisory group] has commedical director had a meetings yet nor was evidence that this phyposition and its responsation and its responsation and its responsation and offered the agency documentation of whe approved, reviewed, and offered the agency process of being retyped. The undated policial Advisory Board states meeting and maintain records Assist in the lath needs and sup assuming its role in the professional advituo sub - committees Committee B. Quality	at 3:20 PM, the d her first day back to work and indicated she had read correction and new policies hat there was no se new polices and ementation of and effective ere was not evidence of any ry work towards the uation. She indicated the the PAG [professional changed and that the new not participated in any there any documentation to recician has agreed to the nsibilities. 1:25 PM, the administrator did not maintain en polices were developed, revised, and implemented by polices were in the oed. y titled "Professional ed, "Minutes are kept of each led in permanent agency dentification of community exports the agency in the alleviation or resolution of the reviews the agency's mends needed changes sory board will function with A. Audit Review Assurance Committee."	{G ·	155}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF DE	AOVIDED OD CURRUED	157577				07/02	2/2012
	ECARE LLC			13	EET ADDRESS, CITY, STATE, ZIP CODE 18 W CARMEL DR ARMEL, IN 46032		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	0,	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	COMPLETION DATE
{G 155}	Professional Advisory patient care and adm	trator shall meet with the Board to review agency inistrative policies and ew shall be documented in	{G 1	55}			
{G 176}	presented an agency and titled "Profession and reviewed. The de attendance at the me director and the adminursing. The docume information notes as a survey and is now sig contains an agency ti 484.30(a) DUTIES OF NURSE	ent contained the same oresented during the first uned by administrator and the head. F THE REGISTERED	{G 1	76}			
	physician and other ppatient's condition and This STANDARD is reasonable and to ensure the register with other entities tha 11) of 1 clinical recordidentified as received other entities and faile summaries included pwas sent to the physician and the physician and the properties of the physician and the properties and the physician and	dinates services, informs the ersonnel of changes in the dineeds. not met as evidenced by: ord and policy review, home interview, the agency failed ed nurse coordinated care the provided services in 1 (# direviewed of patients additional services from ed to ensure 60 day pertinent information and cian in 1 of 2 records (11)					
	where services were	provided for more than 60 al to affect all patients that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BI			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	157577 B. WING R 07/02/2012						
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 138 W CARMEL DR CARMEL, IN 46032	1 01701	
(X4) ID PREFIX TAG	(-, -, -, -, -, -, -, -, -, -, -, -, -, -			ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{G 176}	received home health Findings include: 1. Clinical record # 1 indicated the patient is clinical record evidencertification period 3/3 signed by the administ the certification period signed by the alternation for skilled nursing visition 6-8 hours, 8-10 hours hours,; 2-3 WK [week authorized through mailed to evidence cooproviders of care and included pertinent information for the last. A. An undated the author and signature, patient's application and listed all of the patient's application and listed	1, start of care 12/26/06, required 24 hour care. The ced a plan of care for the 29/12 through 5/27/12 strator and a plan of care for che 29/12 through 7/26/12 strator and a plan of care for che 29/12 through 7/26/12 strator and a plan of care for che 29/12 through 7/26/12 strator and a plan of care for che 29/12 through 7/26/12 strator and a plan of care for che 29/12 through 7/26/12 strator and a plan of care for che 29/12 through 7/26/12 strator and a plan of care for che administrator with orders strator and strator and strator and strator and strator and was sent to the 20 certification of care with other that 60 day summaries for medicaid PA services attents from the same receiving services from this of this patient the document over - 128 hours / month. The direct care staff for some she McSherr , Inc." The conclude any coordination of co	{G ^	176}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII			CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		157577	B. WIN	G			2/2012
	OVIDER OR SUPPLIER			138	T ADDRESS, CITY, STATE, ZIP CODE W CARMEL DR RMEL, IN 46032	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{G 176}	3/29/12 included an a and stated, "Liver bio overnight, no new me changes. Has receiv nurse] service for AD care including bathing [incontinent] care, ski maintenance of speci [treatment], medication feedings. Pleased with D. The plan of constant of the plan of the plan of the caregiver and emadditional care and send of the plan of the plan of the caregiver and emadditional care and send of the plan	are with beginning date area titled "60 day summary" psy 3/20/12, in hospital edications, or medication ed ordered SN [skilled L [activities of daily living] g, dressing, incont in care, foot care, oral care, al equipment, respiratory TX on administration and th care provided." are with beginning date area titled "60 day summary" in the medications and has received ordered SN including bathing, dressing, are, skin care, foot care, are of special equipment, ment], medication edings. Pleased with care ummaries failed to evidence the patients daily care. e visit on 7/2/12 at 10 AM,	{G 1	76}			
		4 times a day to maintain					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157577	B. WIN				⋜ 2/2012
	OVIDER OR SUPPLIER			13	EET ADDRESS, CITY, STATE, ZIP CODE 38 W CARMEL DR ARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICENCY)	D BE	(X5) COMPLETION DATE
{G 242}	allergies, and was characteristic and alternate administrator on 6/28 policy was a new / revidate, titled "Identify P Coordination" stated, designate a common document other provides on the OASIS fibe documented and uchanges." 484.52 EVALUATION PROGRAM This CONDITION is a Based on administrative and interview, agency failed to ensure the ongoing annual event of	a longer go outside due to air / bed bound. 1 2:30 PM, the administrator strator indicated they were nts additional services. 1 2:30 PM, the administrator strator indicated they were nts additional services. 2 3 4 5 6 7 7 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	{G 2				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER	10/0//		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	07/02	2/2012
ABC HOM	ECARE LLC			13	38 W CARMEL DR ARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
{G 242}	in place for the ongoin assessed the policies practices of the agend which the promote parappropriate, adequate (See G 248); and failed place for collection of evaluation (See G 24). The cumulative effect has resulted in the aground compliance with the C 484.52: Evaluation of resulting in the potent of the agency. 484.52 EVALUATION PROGRAM The evaluation consists administrative review. This STANDARD is represented by the ongoing annual exprogram for 1 of 1 agreeffect all patients of the findings include: 1. On June 29, 2012 administrator / alternation indicated she wrote the that there was no documents.	failed to ensure a plan was an annual evaluation that and administrative by to determine the extent to tient care that is an effective and efficient and to ensure a plan was in pertinent data to assist in pertinent and policy and and a clinical record review. The AGENCY'S are of an overall policy and and a clinical record review. The action of the agency and period the reaplan was in place for valuation of the agency's ency with the potential to his agency. The AGENCY and the alternate are also and a single period to the agency's ency with the potential to his agency.	{G 2				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			13	EET ADDRESS, CITY, STATE, ZIP CODE 38 W CARMEL DR ARMEL, IN 46032	1 0770.	2/2012
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{G 244}	professional advisory their plan of correction director was out of to return until after Indep She indicated she had new policies and procesult of the recent suand that the agency cadministrative document an ongoing including the criteria to problems and how to resolution, and addreeffectiveness of the paccomplished and do she does not have coprofessional advisory a member. 2. On June 29, 2012 administrator indicated was June 25, 2012 are some of the plan of cand procedures, the impledate, she indicated the planning or preliminal agency's annual evalumedical director position and documentation to the participated in any meany d	e was not a meeting with the board as documented in n because the new medical wn and not expected to be be be deed and wrote the bedures implemented as a survey and plan of correction did not maintain entation of the new polices agency development and ards how the agency was to gannual program and to prioritize any identified document the agency so how monitoring of the rogram would be cumented. She indicated summunication with the group and that she was not at 3:20 PM, the did her first day back to work and indicated she had read correction and new policies that there was no see new polices and ementation of and effective there was not evidence of any ry work towards the uation. She indicated the ion of the PAG has changed	{G 2	244}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			1:	EET ADDRESS, CITY, STATE, ZIP CODE 38 W CARMEL DR CARMEL, IN 46032	07702	2/2012
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{G 244}	agency does not have implemented infection for the infection contribute of their stanew hand hygiene por CDC web site and washomes and mailed to in the form of a return hygiene techniques a completed when the property supervisory visit. 4. The undated policy Advisory Board" states at least one physician appropriate represent professional discipline each meeting and material and covering the scope of and discharge policies plans of care, emergenty personnel qualification and supports the agest the alleviation or resonant professional advisory sub - committees: A. B. Quality Assurance 5. The undated policy Evaluation" stated, "Formatting and property stated, "Formatting and policy sub - committees and policy sub - committees and policy sub - committees and policy stated, "Formatting and policy stated," Formatting and policy stated, "Formatting and property stated," Formatting and policy stated, "Formatting and property stated," Formatting and property stated, "Formatting and property stated, "Formatting and property stated," Formatting and property stated, "Formatting and property stated," Formatting and property stated, "Formatting and property stated, "Formatting and property stated," Formatting and property stated, "Formatting and property stated, "Formatting and property stated," Formatting and property stated, "Formatting and property stated, "Formatting and property stated," Formatting and property stated, "Formatting and property stated, "Formatting and property stated," Formatting and property stated, "Formatting and property stated," Formatting and property stated, "Formatting and property stated," Formatting and	at 3:30 PM, the or of nursing indicated the er a developed and in control program to monitor oil - compliance of aff. She indicated that the dicy was obtained from the as sent to the patient's the staff and that monitoring in demonstration of hand and compliance will be patient is due for their of t	{G 2	244}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF DE	OVIDER OR SUPPLIER	157577		o		07/0	2/2012
					EET ADDRESS, CITY, STATE, ZIP CODE 88 w Carmel Dr		
ABC HOM	ECARE LLC			C	ARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{G 244}	patient care and admi procedures. The revi the administrative ma shall be summarized Board of Directors." 6. Administrative doc evidence the agency evaluation of its progr policies and procedur review, including crite of any identified probl monitoring of the effer would be accomplished. 7. Review of an undated document dated 5/15. Quality Assurance". assessment donee	Board to review agency inistrative policies and ew shall be documented in nual. Recommendations for presentation to the suments review failed to planned an annual ram and included a review of es and an administrative ria to prioritize the resolution ems, and address how criveness of the program ed and documented.	{G 2	44}			
{G 245}	presented an agency and titled "Profession and reviewed. The do attendance at the medirector and the adminursing. The docume information notes as p	ent contained the same oresented during the first ned by administrator and tle head.	{G 2	45}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SUF COMPLET	
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{G 245}	agency's program is effective and efficier	sses the extent to which the appropriate, adequate, it.	{G 2	245}			
	Based on administr review and interview a plan was in place evaluation that asse agency's program is effective and efficier	not met as evidenced by: ative document and policy t, the agency failed to ensure for an ongoing annual sses the extent to which the appropriate, adequate, at for 1 of 1 agency with the patients served by this					
	administrator / alterr indicated she wrote that there was no do or preliminary work or eview, and that their professional advisor their plan of correctidirector was out of to return until after Inde She indicated she how policies and procedures and that the agency administrative docur and procedures, any agency planning tow document an ongoir including the criteria	2 at 3:10 PM, the alternate nate director of nursing the plan of correction and ocumentation of any planning completed available for re was not a meeting with the y board as documented in on because the new medical own and not expected to ependence Day (7/4/12). and developed and wrote the ocedures implemented as a survey and plan of correction					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF	
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	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 38 W CARMEL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{G 245}	resolution, and addre effectiveness of the p accomplished and do she does not have co professional advisory a member. 2. On June 29, 2012 administrator indicate was June 25, 2012 ar some of the plan of coand procedures and the documentation of the procedures, the impledate, she indicated the planning or preliminal agency's annual evaluated director positional dir	as show monitoring of the rogram would be cumented. She indicated mmunication with the group and that she was not at 3:20 PM, the d her first day back to work and indicated she had read prrection and new policies that there was no see new polices and ementation of and effective ere was not evidence of any ry work towards the pation. She indicated the sion of the PAG has changed dical director had not evidence that this physician sition and its responsibilities. If titled "Professional d, "Membership will include and the permanent country of the permanent country o	{G 2	245}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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		157577	B. Will			07/0	2/2012
	ROVIDER OR SUPPLIER			'	REET ADDRESS, CITY, STATE, ZIP CODE 138 W CARMEL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{G 245}	Periodically reviews to recommends needed professional advisory sub - committees: A. B. Quality Assurance 4. The undated policy Evaluation" stated, "Professional Advisory patient care and adm procedures. The review the administrative mashall be summarized Board of Directors." 5. Administrative docevidence the agency evaluation of its prograpolicies and procedur review, including criterians of any identified problemonitoring of the effect would be accomplished. 6. Review of an undated comment dated 5/15. Quality Assurance". assessment doneeevidence an ongoing	ne agency's programs and changes The board will function with two Audit Review Committee Committee." y titled "Annual Program olicy and Procedure trator shall meet with the Board to review agency inistrative policies and ew shall be documented in nual. Recommendations for presentation to the uments review failed to planned an annual am and included a review of es and an administrative ria to prioritize the resolution ems, and address how ctiveness of the program ed and documented. uted administrative //12 titled "ABC Home Health The document stated "QA"	{G:	245)			
	presented an agency and titled "Profession	the alternate administrator document dated 11/9/11 al Advisory Board Meeting" ocument evidenced the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER ECARE LLC			13	EET ADDRESS, CITY, STATE, ZIP CODE 8 W CARMEL DR ARMEL, IN 46032		
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{G 245}	director and the adminursing. The docume information notes as paurvey and is now sig contains an agency ti 484.52 EVALUATION PROGRAM Results of the evaluation	eting was only the medical nistrator / director of ent contained the same presented during the first ned by administrator and the head. OF THE AGENCY'S	{G 2				
	This STANDARD is repaired and acted up the operation of the athe potential to effect. The findings include: 1. On June 29, 2012 administrator / alternationated she wrote that there was no door preliminary work coreview, and that there professional advisory their plan of correction director was out of tox return until after Indep She indicated she had new policies and processional plan of corrections.	ied issues that could be bon by those responsible for gency for 1 of 1 agency with all patients of the agency. at 3:10 PM, the alternate the director of nursing the plan of correction and the umentation of any planning					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
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	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 38 W CARMEL DR CARMEL, IN 46032	07702	272012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
{G 246}	and procedures, any agency planning toward document an ongoing including the criteria to problems and how to resolution, and addreeffectiveness of the paccomplished and do she does not have coprofessional advisory a member. 2. On June 29, 2012 administrator indicate was June 25, 2012 are some of the plan of continuous and procedures and the documentation of the procedures, the impledate, she indicated the planning or preliminal agency's annual evalumedical director positionand that the new medical director positional director	lid not maintain entation of the new polices agency development and ards how the agency was to gannual program and o prioritize any identified document the agency ss how monitoring of the rogram would be cumented. She indicated immunication with the group and that she was not at 3:20 PM, the d her first day back to work and indicated she had read correction and new policies hat there was no se new polices and ementation of and effective ere was not evidence of any ry work towards the uation. She indicated the ion of the PAG has changed lical director had not eletings yet nor was there of evidence that this physician sition and its responsibilities. at 3:30 PM, the or of nursing indicated the ere a developed and in control program to monitor	{G 2	246}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R	
		157577		·		07/02	2/2012
	ROVIDER OR SUPPLIER			13	EET ADDRESS, CITY, STATE, ZIP CODE 88 W CARMEL DR ARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{G 246}	and mailed to the star form of a return demotechniques and compwhen the patient is did. 4. The undated policy Board" stated, "Membone physician, one reappropriate represent professional discipline each meeting and made agency records. Fund the establishment and covering the scope of and discharge policie plans of care, emerge personnel qualification Assist in identification and supports the age the alleviation or rescommends needed professional advisory sub - committees: A. B. Quality Assurance 5. The undated policie Evaluation" stated, "Freview: The administrative made and procedures. The revithe administrative mashall be summarized Board of Directors."	ff and that monitoring in the constration of hand hygiene diance will be completed use for their supervisory visit. If titled "Professional Advisory pership will include at least egistered nurse, and tation from other less Minutes are kept of sintained in permanent ctions: Participates in dannual review of policies if services offered, admission is, medical supervision, ency care, clinical records, ins, and program evaluation. In of community health needs incy in assuming its role in community health needs incy in assuming its role in community health needs incy in assuming its role in community health needs incy in assuming its role in community health needs incy in assuming its role in community health needs incy in assuming its role in community health needs in the agency's programs and changes The board will function with two audit Review Committee. The board to review agency inistrative policies and ew shall be documented in inval. Recommendations for presentation to the suments review failed to	{G 2	246}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157577	B. WING		07/	R	
NAME OF PR	OVIDER OR SUPPLIER	10.077		STREET ADDRESS, CITY, STATE, ZIP CC	•	02/2012	
ABC HOM	ECARE LLC			138 W CARMEL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{G 246}	policies and procedur review, including crite of any identified probl	ram and included a review of res and an administrative ria to prioritize the resolution dems, and address how ctiveness of the program	{G 2	46}			
	presented an agency and titled "Profession and reviewed. The d attendance at the me director and the admi nursing. The docume information notes as	ent contained the same presented during the first ned by administrator and					
{G 248}	Quality Assurance". assessment donee evidence an ongoing evaluation to identify patient care.	/12 titled "ABC Home Health The document stated "QA	{G 2	48}			
	administrative practic reviewed to	to which they promote propriate, adequate,					
	This STANDARD is r	not met as evidenced by:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157577	B. WIN	G			? 2/2012
	ROVIDER OR SUPPLIER		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 38 W CARMEL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
{G 248}	Based on administrar review and interview, a plan was in place for evaluation that asses policies and administrate agency to determine a promote patient care adequate, effective as with the potential to enthis agency. The findings include: 1. On June 29, 2012 administrator / alternatindicated she wrote the that there was no door preliminary work conceived, and that there professional advisory their plan of correction director was out of tower than the professional advisory their plan of correction director was out of tower than the plan of correction director was out of tower than the policies and proceived and that the agency cannot be administrative document an ongoing including the criteria tower problems and how to resolution, and addree effectiveness of the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and do she does not have contained to the paccomplished and the paccomplished to the paccomplished and the paccomplished and the paccomplished the paccomplis	tive document and policy the agency failed to ensure or the ongoing annual sed and reviewed the rative practices of the the extent to which the that is appropriate, and efficient for 1 of 1 agency ffect all patients served by at 3:10 PM, the alternate attent director of nursing the plan of correction and the sumentation of any planning to explain a documented in the board as documented as a three program and the program and the program and the program would be the comented. She indicated	{G 2	248}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	ED
		157577	B. WIN	G		07/02	≺ 2/2012
	ROVIDER OR SUPPLIER		.	1	REET ADDRESS, CITY, STATE, ZIP CODE 138 W CARMEL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{G 248}	was June 25, 2012 at some of the plan of cand procedures and the documentation of the procedures, the impledate, she indicated the planning or preliminal agency's annual evalumedical director position and that the new medical director position and that the new medical director position and that the new medical director position and documentation to has agreed to the position and the position and that the new medical director position and documentation to has agreed to the position and the position and discontinuous professional disciplinate ach meeting and material agreed to the position and discharge policie plans of care, emergence personnel qualification and supports the agency records. Fund the establishment and covering the scope of and discharge policie plans of care, emergence personnel qualification and supports the agency records. Periodically reviews the recommends needed professional advisory	at 3:20 PM, the ad her first day back to work and indicated she had read correction and new policies that there was no se new polices and ementation of and effective here was not evidence of any ry work towards the function. She indicated the higher indicated t	{G 2	248}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157577	B. WIN				₹
NAME OF PR	OVIDER OR SUPPLIER	197977		STREET A	DDRESS, CITY, STATE, ZIP CODE	07/02	2/2012
ABC HOM	ECARE LLC			138 W (CARMEL DR		
0/0/15	CHIMMADV CT	ATEMENT OF DEFICIENCIES	ID.	CARM	EL, IN 46032	ON	9/5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{G 248}	Continued From page	e 35	{G 2	48}			
	Evaluation" stated, "F Review: The administ Professional Advisory patient care and adm procedures. The review the administrative man shall be summarized Board of Directors." 5. Administrative documents and procedures and procedures and procedures and procedures including criterio of any identified problem.	strator shall meet with the a Board to review agency inistrative policies and ew shall be documented in anual. Recommendations for presentation to the suments review failed to planned an annual ram and included a review of ees and an administrative eria to prioritize the resolution dems, and address how ctiveness of the program					
{G 249}	presented an agency and titled "Profession and reviewed. The dattendance at the me director and the adminursing. The docume information notes as survey and is now sig contains an agency ti 484.52(a) POLICY AT REVIEW Mechanisms are esta collection of pertinent	ent contained the same presented during the first ned by administrator and	{G 2	49}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157577	B. WIN	G			⋜ 2/2012	
NAME OF PROVIDER OR SUPPLIER ABC HOMECARE LLC				13	EET ADDRESS, CITY, STATE, ZIP CODE 88 W CARMEL DR ARMEL, IN 46032	0770	2/2012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE COMPLETIC THE APPROPRIATE DATE		
	review and interview, an ongoing plan was the collection of pertinagency evaluation for potential to affect all the The findings include: 1. On June 29, 2012 administrator / alternational administrator / alternational advisory their plan of correctional advisory and that the agency of administrative document and procedures, any agency planning toward document an ongoing including the criterial to problems and how to resolution, and addresses of the placeomplished and do she does not have corressional advisory a member.	tive document and policy the agency failed to ensure developed and in place for ment data to assist in the r 1 of 1 agency with the the agency's patients. at 3:10 PM, the alternate ate director of nursing ne plan of correction and cumentation of any planning completed available for the was not a meeting with the r board as documented in n because the new medical win and not expected to pendence Day (7/4/12). In developed and wrote the cedures implemented as a curvey and plan of correction did not maintain mentation of the new polices agency development and ards how the agency was to granual program and to prioritize any identified document the agency ss how monitoring of the morgram would be formunication with the r group and that she was not	{G 2	249}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157577	B. WING			R 07/02/2012		
NAME OF PROVIDER OR SUPPLIER ABC HOMECARE LLC			•	1	REET ADDRESS, CITY, STATE, ZIP CODE 138 W CARMEL DR CARMEL, IN 46032		-	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
{G 249}	was June 25, 2012 ar some of the plan of commendation of the procedures, the imple date, she indicated the planning or preliminar agency's annual evaluation discontinuous and that the new medical director position and that the new medical director position and that the new medical director position and documentation to has agreed to the position and supportate represent professional discipline each meeting and madigency records. Fund the establishment and covering the scope of and discharge policies plans of care, emergency personnel qualification and supports the agent the alleviation or resonal discontinuous periodically reviews the recommends needed professional advisory sub - committees: A. B. Quality Assurance 4. The undated policies and professional stated, "Periodicallor" stated,	and indicated she had read correction and new policies that there was no see new polices and mentation of and effective ere was not evidence of any y work towards the pation. She indicated the ston of the PAG has changed ical director had not eetings yet nor was there evidence that this physician sition and its responsibilities. If titled "Professional degree in the professional degree in the period of intained in permanent ections: Minutes are kept of intained in permanent ections: Participates in the annual review of policies services offered, admission in the permanent ections in the permanent ection in the permanent ection in the permanent ection in the permanent ections in the permanent ection in the permanent ection in th	{G 2	249}				

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NAME OF PROVIDER OR SUPPLIER ABC HOMECARE LLC				1	REET ADDRESS, CITY, STATE, ZIP CODE 138 W CARMEL DR CARMEL, IN 46032		2/2012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE		
{G 249}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		{G :	249}				